Creating a Coordinated System of Home Visiting for Families with Young Children

Draft for Public Comment

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Contents

Introduction

Public Act 13-178, signed into law June 24, 2013, calls for a comprehensive plan to meet the mental, emotional and behavioral health needs of children in Connecticut. The legislation charges the State's Office of Early Childhood, through the Early Childhood Cabinet, to deliver recommendations to coordinate the state's home visiting programs by December 1, 2014.

The legislation calls for recommendations for coordinated home visiting services that serve young children of families experiencing, or likely to experience, poverty, trauma, violence, teen parenthood and health challenges, including, mental, emotional or behavioral health or substance abuse issues. According to the statute, the recommendations should address, at minimum:

1. A common home visiting referral process;
2. Core competencies and training for home visiting staff;
3. Core standards and outcomes for programs, and a monitoring framework;
4. Coordinating cultural competency, mental health, childhood trauma, poverty, literacy and language acquisition training being provided for home visiting and early care providers;
5. Development of common outcomes;
6. Shared annual reporting of outcomes, including identifying gaps in services, pursuant to C.G.S. 11-4a;
7. Home-based severe depression treatment options for parents of young children;
8. Intensive intervention, including relationship-focused intervention, for children experiencing mental, emotional or behavioral health issues.

Prompted by this legislation the Office of Early Childhood convened a workgroup to develop recommendations for several initial components of a coordinated system of home visiting within early childhood.

The Office of Early Childhood is submitting this report generated by the workgroup in response to the legislative mandate described above. The recommendations submitted reflect a first step toward creating a fully coordinated system of home visiting that is integrated into Connecticut's mental health, family support, early care and education, health, and comprehensive early childhood service systems. The Office of Early Childhood recognizes the need for continued efforts to build on these initial recommendations.

Guiding Principles

To guide the development of a coordinated system of home visiting programs as a component of a comprehensive early childhood system, this workgroup recommends focusing on the following guiding principles:

- Children's earliest experiences have a major impact on their development.
- Home visiting is an effective approach to strengthening families across multiple generations.
- All aspects of the home visiting system must be family-centered, strengths-based, trauma-informed, multi-generational, relationship-based, and family-driven.
- Families should have access to the supportive services they need.
- The diversity of Connecticut's home visiting programs is a strength of our system, enabling the form and intensity of the service to match the priorities and level of need of the child and family as the child's age and the family's need for services evolves over time.
- Home visiting programs implemented should be effective (evidence-based, evidence-informed or use promising practices).
- A strong financial base will allow for access to affordable high-quality home visiting programs to meet the needs of all families.
- Programs should be coordinated and collaborative so families do not have to go without needed services because of gaps or disconnects in the system.
- The coordinated system should include all home visiting programs.
- The Connecticut system for home visiting programs is an important component of the service landscape that supports families with young children.
- All state agencies should collaborate in support of a comprehensive early childhood and family support services system.

What Is Home Visiting?

Home visiting is a powerful strategy to promote child wellness and development, strengthen families, and prevent child abuse neglect and maltreatment in Connecticut. Home visiting services are *v*oluntary, sustained efforts that pair families with trained staff to provide parenting information, resources and support during pregnancy and throughout the child's first eight years.

Who Is Home Visiting For?

Connecticut home visiting programs serve expectant parents, families and other caregivers of children birth through age eight. Program staff build on family strengths and provide individual support focused on both the caregiver (often a, expectant mother, parent grandparent, foster, parent, or child care provider) and the child or children. Program staff conduct assessments to ensure the services are appropriate for the family.

Why Home Visiting?

Early childhood home visiting is an effective prevention strategy that improves public health outcomes. Research tells us that adverse childhood experiences have a significant impact on long-term adult mental and physical health (http://acestudy.org/). Research also shows that the earlier in a child's life home visiting support is provided, the greater the potential for having long-lasting positive results. Quality research-based home visiting efforts:

- improve healthy child development across all domains (language development, cognition, physical development, social and emotional development, etc.)
- Improve pregnancy birth outcomes and preconception, prenatal, and inter-conception care;
- reduce emergency department visits and hospitalization;
- improve school readiness and decrease the achievement gap;
- reduce crime and domestic violence;
- improve maternal and child health,;
- improve family economic self-sufficiency; and
- prevent child injuries, child abuse, neglect, and maltreatment; and
- improve the coordination of and referrals to other community resources and supports.

What Is the Cost of Doing Nothing?

Preterm Births

- **$26.2 billion** annual costs nationwide associated with premature births (which make up 7% of births in CT in 2013)[1]
    - The *additional annual cost* per infant born preterm is **$51,600**.

Child Abuse and Neglect

- **$124 billion** total lifetime economic burden of all maltreated children in the US in 2008[2]. **39%** of child abuse cases occur in the first four years of life and evidence-based home visiting can reduce the incidence of child maltreatment by **50%**
    - The *lifetime cost* of one victim of maltreatment due to adverse health, mental health and economic consequences of maltreatment is **$210,012.**

Special Education

- **$1.7 billion** annual cost of special education services in Connecticut and only 10% of costs paid for by Federal funds. Special education funding makes up over **21% of total education spending** in Connecticut and costs are growing at an average of 5-6% per year.[3]
    - The *annual cost* per child of special education in CT is approximately **$16,000.**

[1] Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. Preterm Birth: Causes, Consequences, and Prevention. Washington (DC): National Academies Press (US); 2007. 12, Societal Costs of Preterm Birth. Available from: http://www.ncbi.nlm.nih.gov/books/NBK11358/

[2] http://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html

[3] CT Conference on Municipalities Public Policy Report, November 2012, Education Finance in Connecticut

What home visiting programs are in CT?

There are many home visiting programs in Connecticut that provide services to families in their homes. For the purposes of this report, the following programs have been included because they serve families with children under age eight and provide the majority of their services in a family's home (or other environment of their choice). The majority of the recommendations in this report are applicable to the home visiting programs listed below, which make up the bulk of home visiting programs in the state open to any family (provided they meet eligibility guidelines).

- Birth to Three
- Case Management for Pregnant Women
- Child First
- Early Head Start
- Family Resource Centers
- Healthy Start
- Family School Connection Project
- Minding the Baby
- Nurturing Families Network
- Nurse Family Partnership
- Parents as Teachers
- Putting on Airs
- Young Parents Program

Several home visiting programs within the Department of Children and Families (DCF), while an important part of the home visiting field, are available only to families facing allegations or substantiations of abuse and neglect. For this reason, several recommendations such as those regarding referrals, marketing, reporting do not apply to DCF programs. However, recommendations to improve the quality of programs and the experience of families are also valuable for DCF programs. The DCF home visiting programs are listed below.

- Building Blocks
- Caregivers Support Team
- Early Childhood Parents in Partnership
- Family Enrichment Services
- Family Support Team
- Integrated Family Violence Services
- Intensive Home Based Services
- Positive Parenting

A Vision for a Coordinated Network of Home Visiting Programs in Connecticut

Our vision for a system of home visiting is to ensure that all families will have access to the home-based services and supports they need and those programs are fully embedded in other

systems of care such as health, mental health, early childhood services, and early care and education.

For Families:

Families will voluntarily welcome the support provided without stigma because:

- families are respected as partners;
- support is available for all parents and other caregivers; and
- the support provided is non-judgmental, culturally appropriate, builds upon family strengths, and is of value to the family.

For Programs:

Programs will be part of a coordinated network that ensures:

- a diverse set of programs are available to meet a broad range of family and child needs;
- funding is available to provide appropriate supports for the needs of all families and children; and
- services are easy to access, well-coordinated, and adapt over time to changing needs of families in Connecticut.

For State Support:

The State will invest in high-quality home visiting programs because of their significant collective impact on families and Connecticut as a whole.

Existing Capacity and Gaps: Connecticut's Current Home Visiting Programs

Raising babies and young children is hard for any family. But statewide in Connecticut, a large number of families with young children face additional challenges that make raising a young child even harder.

The Department of Public Health's *Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting Programs* (2010) identified key data that describe the population of people who could benefit most from home visiting services. These data sets have been updated to give a more accurate portrait of need in the state for home visiting services and are described below. (The full data report available in Appendix B.) This data includes both outcomes and risk factor data that help paint a portrait of the need for home visiting services in Connecticut including:

- **Maternal, Birth, and Infant Outcomes and Risk Factors,**
- **Child Health and Development Outcomes and Risk Factors**

Note: For the following numbers, there is variability for the age range presented because of the variability of reported data. The top ages range from 4 to 10 by data point. The exact ages and sources are available in the Appendix B.

According to the most current data available, there is an annual capacity to serve approximately 10,500 families in home visiting programs (Note: this figure is still an estimate in draft form) . By comparison, there are approximately 365,000 children under the age of six years old. Of those children under the age of six, 71,300 are living in single-parent families, and almost 400 are living in homeless shelters.

Each year, there are approximately 37,000 births in Connecticut. About 3,500 babies are born at a low birth weight, 13,800 are born into poverty (200 percent of federal poverty line or below), 2,000 are born to teen mothers, and are 4,800 born with little or no prenatal care.

Approximately 27,000 children under the age of five are read to less than three days per week, 2,000 children age 10 and under are in foster care, and an estimated 8,400 children under 18 have parent who is incarcerated.

The impact on young children being raised in challenging circumstances is significant. There are approximately 81,000 allegations of abuse or neglect in Connecticut for children 18 and under each year, 30,000 are accepted by the DCF care line, and 4,900 are substantiated. In 2012, 3,000 of the allegations involved children birth to four years and 2,600 involved children five to 10 years old. 570 children under the age of nine have been involved or present during

domestic violence incidents. A high level comparison between the numbers of families facing different challenges and the current availability of home visiting programs demonstrates the unmet need for services. Even when this report's recommendations are implemented and a more coordinated home visiting system is built, the total capacity of home visiting programs will not come close to meet the needs of families and children.

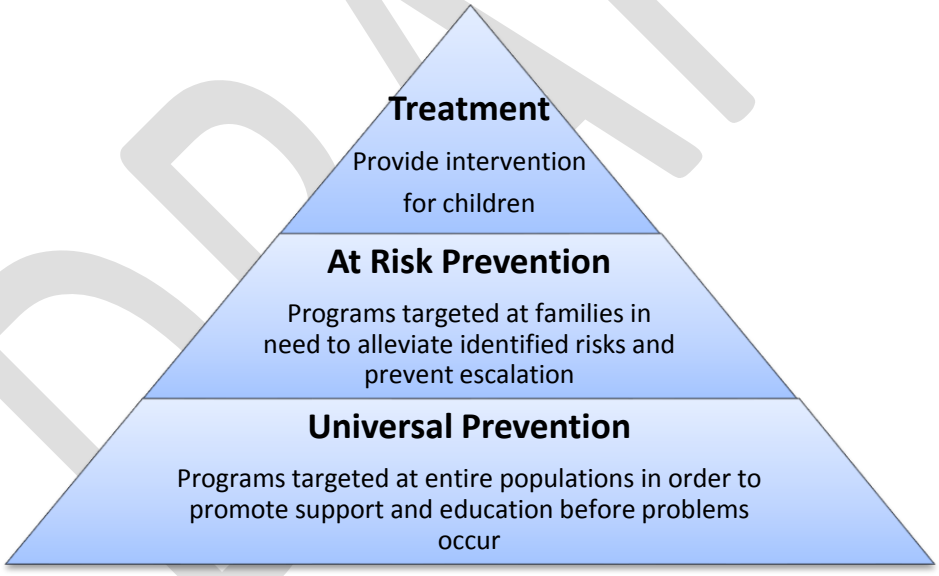
Recommendations

A) Develop a System of Home Visiting that Provides Families Access to a Continuum of Home Visiting Programs

Families benefit from a wide menu of home visiting programs in order to ensure they have access to a program that best meets their needs. Families should benefit most when they are matched with programs that are well suited to support them in achieving a desired outcome. Providing families access to a range of programs requires effort to ensure they work together as a coordinated system that families find easy to navigate and use.

Public Health Pyramid Model of Intervention

The Pyramid Model of public health services is a framework for describing different levels of intensity of program intervention and can be used to differentiate between different home visiting programs. The public health model categorizes services according to three levels: [4]



- Treatment (Tertiary): Services specifically designed for families who have children with special health care needs, significant emotional or behavioral problems, or families in which a negative outcome such as child abuse or neglect has already occurred. These

4 Hunter, Catherine, 2011. "Defining the Public Health Model for the Child Welfare Services Context." Australian Institute of Family Studies. Web. 10 September 2014. < *https://www3.aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-servi*> p

interventions seek to reduce the long-term implications of child mental health problems, developmental delays, and to prevent maltreatment from recurring.

- At Risk Prevention (Secondary): Programs specifically designed for families with children with developmental delays or who have risk factors for poor outcomes such as poor birth outcomes, poor maternal or child health, or child abuse and neglect. These risk factors may include circumstances such as poverty, parental mental health problems, marital discord, family violence, or parental drug or alcohol use.
- Universal Prevention (Primary): Strategies designed for whole communities or populations in order to build public resources and education enhance the social factors that can prevent poor outcomes in the population as a whole such as poor developmental, mental health, or health outcomes (including pregnancy, maternal, and child health).

In Connecticut, the needs of families vary greatly and there a broad portfolio of programs that deliver services in the home in Connecticut. Tiers, or levels of intensity and intervention, can be differentiated by several factors, as noted below.[5] Each program is designed to meet different child and family needs using different approaches and these programs are described and compared in more detail in Appendix E. A list of the different differentiating aspects of programs is described below.

- *Primary risk factors* the home visiting strategy is designed to address.
    - For example Child First addresses families at risk of child abuse or neglect, Early Head Start promotes school readiness for families below the federal poverty line, and Birth to Three addresses developmental delays.
- *Education, training and discipline of the staff*. Programs employ different levels of professionals who deliver home visiting programs.
    - For example, Nurse Family Partnership employs registered nurses and Nurturing Families Network employs trained family support home visitor, both BA and paraprofessional level.
- *Evaluated program content and outcomes*. Some programs have research that demonstrates different positive outcomes achieved as a consequence of program participation.
- *Frequency of visits*. Programs may visit families with different frequencies
    - For example, some programs visit families several times a week and others once a month.

5 These examples are drawn from the Arizona home visiting Plan.

- *Length of program participation*. The length of program participation may vary according to the intended population, goals, and objectives of the intervention.
    - For example, a program designed to reduce the risk of abuse and neglect may begin prenatally with the goal of providing support to the family until the child enters kindergarten. Another program designed to support healthy birth outcomes may begin during pregnancy and extend through the first year or two of the baby's life. A program designed for children with emotional and behavioral problems may begin any time in the first five years of life and last 9-12 months.

Recommendations:

1. **Secure additional funding from all available sources to expand capacity of the home visiting system to meet the needs of families and children.**

Potential additional sources of funding include:

- Connecticut State General Fund
- Interagency collaborative funding (including OEC, DCF, DSS, SDE, DDS, DPH, DMHAS)
- Federal grant funding
- Medicaid funding
- Social Impact Bonds
- Private funding

2. **Provide a menu of home visiting programs that will help match families with the most appropriate program.**

A menu of programs that clearly highlights the differentiating features of each program (such the population to be served or the expected impact or outcomes for families) should be available to both to families and also to people who help families find services.

3. **Expand the capacity of the home visiting system to serve parents with depression and children experiencing mental, emotional, or behavioral health issues.**

Screen all parents for depression. All programs should have the responsibility for either providing or attempting to refer caregivers to services for their depression.

Expand the use of Medicaid funding to pay for in-home cognitive behavioral therapy. Approximately 45 percent of mothers in a home visiting program were found to be suffering from depression (Ammerman, Putnam, et al., in press, *Child Abuse & Neglect*). Because of lack of transportation, scheduling conflicts, lack of child care, and concerns about stigma, many new mothers do not access care for depression. Recent Medicaid billing changes have opened the door for in-home therapy and Nurturing Families Network began a pilot to develop a cohort of

therapists trained and ready to provide in-home treatment. Additional funding is needed to develop this workforce and embed those services in the home visiting system.

Expand the capacity of home visiting programs able to treat families experiencing mental, emotional, or behavioral health issues.

4. Establish standards to guide the development of a home visiting system.

The field should adopt the following standards to guide the development of the home visiting system in Connecticut.

Families and children have adequate access to home visiting programs. The system is designed to ensure that families have information about home visiting as well as have access to a home visiting program appropriate to their needs.

Home visiting programs collaborate. All home visiting programs refer to one another regularly, communicate with each other regularly, transfer to other home visiting programs whenever indicated by the needs of the child and parents, and work together toward system goals and common outcomes. Home visiting programs, early care and education settings, and other early childhood services (including those that serve young parents) are connected with each other to achieve optimal outcomes for children and their caregivers. This should include a two-generational focus that includes services for young adults, domestic violence, homelessness, adult depression, pregnancy, food security, justice system, substance abuse, and healthcare.[6]To achieve this, there should be the following:

- Support for local planning and local collaboration between programs[7]
- A shared a data system for home visiting that links to other services and databases, as appropriate, to facilitate communication and long-term follow-up

State agencies govern the statewide home visiting system. State agencies regularly assess the available funding, the statewide unmet need for services and system-wide process and outcome performance measures. State agencies monitor the quality of programs funded using tools such as external, third-party program evaluations.

A collaborative working group promotes the ongoing development and improvement of the home visiting system. A home visiting collaborative working group, The Home Visiting

[6] Such as WIC, SNAP, HUSKY, The Mobile Crisis Intervention Team, or The Recovery Specialist Voluntary Program (RSVP).

[7] Such as the Discovery Communities or the Department of Mental Health and Addiction Services' SAMMS project.

Collaborative, is established and managed to promote cross-agency and cross-program collaboration, capture feedback on the performance of the system, and help identify potential improvements of the system.[8] This group would foster collaborative learning, open dialogue and problem solving. It would help implement many of the recommendations of this report, develop and manage an implementation plan for specific recommendations, and build system-wide partnerships and linkages with other service systems. This Home Visiting Collaborative would include the programs of the Department of Children and Families to foster collaboration between prevention and intervention programs.

[8] Such as DMHAS Core Management Team, on ongoing working group, a Continuous Quality Improvement Committee, or a subcommittee to the Early Childhood Cabinet. This group governance structure should include broad representation from many stakeholder groups.

B) Ensure Program Standards Promote High-Quality Programs

Many home visiting programs in Connecticut already have robust program standards. Programs use standards to ensure fidelity to the evidence-based model that is being implemented in order to conduct research and maintain funding. Typical program standards include:

- Initial assessment/screening
- Intake procedure
- Written service plan/goals
- Staffing plan
- Frequency and duration of visits
- Appropriate competencies (see core desired competencies)
- Supervisory oversight and monitoring
- Data gathering
- Feedback collected from those receiving services
- Ongoing, periodic assessment/outcome measurement
- Program exit procedure, including assessment and connection to other services

5. Build on strong existing program standards to maintain model fidelity.

The Home Visiting Collaborative, as described in Recommendation 4, could support a process of quality improvement and learning to encourage programs to share best practices and improve standards and policies where appropriate. Additional funding should be available to conduct research on programs that have not had the opportunity or benefit of a formal evaluation. The program standards that govern programs' operations are as diverse as the home visiting models. While standardizing them could jeopardize their ability to serve the needs of the families they are designed to support, creating a forum for dialog and reflection on program improvement will strengthen all programs.

C) Adopt Common Outcomes for All Home Visiting Programs

The diversity of home visiting programs in Connecticut means that each program helps families in different ways to achieve different outcomes. Individual home visiting programs report to funders, researchers, and the legislature on program specific outcomes. The Children's Report card tracks population-level outcomes.

There is an opportunity to better measure the collective impact of the home visiting programs in Connecticut on children and families. All home visiting programs support families raising young children and help them navigate the varied challenges they face. A common set of outcomes that span most, if not all, programs should be developed to show the collective impact of home visiting programs on children and families. While a set of common outcomes may not reflect every program's primary charge, they can set expectations for the field about the impact every home visiting program should strive to have, either by providing direct service or by referring a family to other appropriate services.

Strengthening Families Protective Factors Framework

Strengthening Families is a national movement to improve child well-being that has identified five protective factors that help to keep all families strong and on a pathway of healthy development. The Connecticut Department of Children and Families is embracing Strengthening Families as a fundamental reform in how it conducts its child welfare services.[9] The Strengthening Families approach has served as a framework for cross-sector collaboration in other states and could serve as an effective outcomes framework in Connecticut.

The foundation of the Strengthening Families approach are five interrelated protective factors that studies show are related to the promotion of family strengths and optimal child development. Research also shows that when these Protective Factors are well-established in a family, the likelihood of child abuse and neglect diminishes. (Center for the Study of Social Policy, September 2014)

- **Concrete Support in Times of Need**: Identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; receiving a quality of service designed to preserve parents' dignity and promote healthy development.

[9] http://www.ct.gov/dcf/cwp/view.asp?a=4247&Q=500504

- **Knowledge of Parenting and Child Development**: Understanding the unique aspects of child development; implementing developmentally and contextually appropriate best parenting practices.
- **Parental Resilience**: Managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity; the outcome is positive change and growth.
- **Social and Emotional Competence of Children**: Providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
- **Social Connections**: Having healthy, sustained relationships with people, institutions, the community, or a force greater than oneself.

Each of the five protective factors is inextricably linked to healthy development and well-being for both parents and their children. For example:

- Gaining more knowledge of parenting and child development enables parents to know and provide what young children need most in order to thrive (e.g., nurturing, responsive, reliable, and trusting relationships; regular and consistent routines; interactive language experiences; and opportunities to learn by doing).
- When parents identify, seek, and receive respectful and timely concrete support in times of need, this helps to ensure they and their children receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational, or legal services.

Recommendations:

6. **Use the Protective Factors Framework as a framework for home visiting outcomes and cross-agency collaboration.**

7. **Use the Home Visiting Collaborative to develop a set of specific common outcomes within the Five Protective Factors Framework that to which all home visiting programs should contribute.**

   The following outcomes are examples of potential common outcomes that may be formally adopted after further study and input from the field and from families.[10] (Examples not yet included.)

[10] Such as: Access to prenatal, maternal, and child health care, family engagement and leadership

D) Strengthen Home Visiting System Referral Infrastructure[11]

Families who need support should be able to find and access the program or programs they need easily. While there are many investments in referral and intake infrastructure already in place, they are not sufficiently funded to reach all families in Connecticut. Additional funding to bolster intake and referral supports is required.

A vision for a referral and intake system

A strong referral system for families entering voluntary home visiting programs should have the following characteristics:

- Multiple channels for families to enter the home visiting system. There is no "wrong door" – that is considered unacceptable for system entry.
- The first engagement is recognized as critical. Families feel heard and do not feel judged; it facilitates the development of trust. Programs regularly refer families to other home visiting programs when appropriate. Families don't have to tell their story again and again in order to obtain services, and data is shared where appropriate.
- Families are routinely screened as part of the referral process by people who are appropriately trained.
- The Child Development Info line of 211 provides a central clearinghouse for referrals and entry into programs. Staff are knowledgeable about each program and make recommendations to families appropriately.
- Relevant data about the family is housed centrally statewide to facilitate sharing and is accessible to those programs serving the family.

Recommendations:

8. **Expand and strengthen the capacity of referral infrastructure: Child Development Infoline (CDI)**

Child Development Infoline (CDI) is a part of the 211 system that provides information and referral, care coordination, and data analysis for Connecticut's social services. CDI provides referral and information currently for the Birth to Three system, Help Me Grow, MEICHV home visiting programs, and children's special healthcare needs.

Increase Call Volume Capacity. Allocate additional funds for an information campaign to promote CDI's services and additional funds to CDI to serve increased call volume. Expand capacity of CDI and promote use of the directory more widely as a referral resource.

[11] Referrals should include the DCF home based programs, if age eligible and voluntary.

Develop a Home Visiting Database. Enhance CDI's database to include the entire field of home visiting programs. Allocate additional funds for CDI to maintain a comprehensive directory of home visiting programs. The database should be developed based on the Birth to Three CDI database to allow for data sharing to facilitate referrals. This database should be integrated into the Early Childhood Information System (ECIS). The system should use the ECIS unique child identifier (The State Department of Education's SASID) or family identifier. If possible, the ECIS data system should be linked to other data systems such as to the Department of Public Health (DPH)'s unique identifiers. This, and other connections, should be explored for feasibility and legality under regulations under HIPPA and FERPA.

Improve the referral process of CDI staff for all home visiting programs.

- CDI staff should receive additional training so they are knowledgeable about every home visiting program in order to effectively refer to all available programs.
- CDI should create a standard CDI protocol where referrals should be made based on a gentle exploration of issues to gather information[12] and then compared to an algorithm or matrix of available resources searchable by age, level of need, and type of home visiting service.
- 211's protocol for other types of calls should be modified to ask if there are young children in the house. For example, for calls about housing or substance abuse where there are young children in the house, 211 should routinely inform the family about home visiting programs.

Increase the data analysis role of CDI. CDI's database of requests and the availability of home visiting programs should be regularly used for system governance, capacity planning, and gap analysis.

9. Increase the local, community-based, grassroots referrals to home visiting programs.

Engage and train community leaders and service providers to refer to home visiting programs. Build the capacity of community leaders (parents, health care professionals, early care and education staff, substance abuse counselors, social workers, pastors, WIC office staff, etc.) who have established and trusted relationships with families within their communities to assist in referring to home visiting programs. Ensure they can communicate the value of home visiting and know how to use CDI to refer a family. Nurturing Families Network's agreements to visit birthing hospitals to speak with new mothers is a practice that could be expanded and built upon.

[12] Perhaps an early identification of strengths, critical issues, and families' goals and risks

Ensure home visiting staff refers to other home visiting programs as appropriate. Ensure all home visiting programs have a screening process as part of their intake/referral protocol and use information from the screening process to make referrals if another home visiting program would be of value to a family. Ensure home visiting staff has sufficient knowledge of other home visiting programs and know how to use CDI to facilitate a referral. Maintain a feedback loop to inform the referring organization of the success of the referral.

Create an easier basic intake process shared by all programs. Explore the use of a swipe card for conveying personal data for individuals that can be used across the system (similar to cards issued by the Department of Social Services) or create a uniform intake/referral form of basic family information to be used by all home visiting programs and CDI to facilitate referral.

10. Improve public awareness and perception of home visiting programs.

Conduct a marketing campaign for home visiting to increase awareness of services available. Include a clear public message for families about what home visiting is that CDI and all home visiting programs can use to supplement their own efforts. Research has shown that the phrase "home visiting" does not resonate with families. Develop another way of describing home visiting that talks about the services provided or the benefit to families, not the method of service delivery only. Where possible, describe home visiting along with other family supports available.

E) Establish a Core Set of Competencies

The Core Competencies of the system describe the skills, knowledge, values and disposition (what to do and how to do it) that staff in every program must have, regardless of the diversity of programs. Once developed, these core competencies should be used to identify opportunities for shared training and workforce development.

Recommendations:

11. **Develop Core Knowledge and Competencies that connect across all early childhood disciplines and services.**

The OEC should develop a framework or method to ensure that as Core Competencies are developed, they are aligned between the early care and education field and the home visiting field. This framework or method would help ensure that there are shared expectations for the most essential knowledge and skills of staff working with young children and families, regardless of the specific service or setting. The result of common expectations is the benefit of agreement that every early childhood discipline recommends the ability to infuse knowledge into practice regarding trauma or child development, recognizes the value of play, and embraces the components of quality observation. This would allow for greater ability to share training and professional development resources across home visiting and early care and education.[13]

12. Adopt a set of Core Competencies for all home visiting roles.

The OEC, with the help of the Home Visiting Collaborative, will help develop a set of Core Competencies for home visiting roles. To be successful, this process should be thorough and well planned with support from national leaders in professional development and workforce initiatives (such as the PDW Center). This process would require an evaluation of existing home visiting competencies and the need to identify the different staffing roles within home visiting programs and the subsequent knowledge and skills (competency level) desired for each staff role. The field will need to agree on a core set of competencies and identify competency areas that programs need additional support to achieve.

[13] Nebraska's Early Childhood Integrated Skills & Competencies for Professionals is an example a high-level framework. OEC's teacher role Core Knowledge and Competencies could also serve as a common core for every set of Core Knowledge and Competencies across the early care and education field. (See Appendix for Nebraska Example)

F) Coordinate Training for Home Visiting Program Staff

In order to develop an appropriately skilled workforce for home visiting programs, sufficient resources should be allocated to ensure the workforce is well trained. Training and professional development support should be available for all home visiting staff on the Core Competencies they are expected to have. This will include such things as cultural competency, mental health, fatherhood, childhood trauma, safety in the home, mandated reporting (DCF), poverty, the needs of expectant mothers, literacy and language acquisition.

Recommendations:

13. Make *existing* training resources more easily available to all home visiting programs.

State agencies should agree to allow all home visiting programs access to their training resources as resources allow. OEC should identify and publicize the available trainings and trainers with expertise to provide training, mentoring, or coaching to home visiting staff. This could be potentially be done through existing infrastructure, such as the Charts-A-Course Registry.

14. Study the home visiting workforce.

State agencies, with help from the Home Visiting Collaborative, should research the size, makeup, and skills of the existing home visiting workforce[14] and assess the statewide need for training and workforce development.

15. Support all home visiting programs through the use of a central training institute.

The OEC is currently developing a quality improvement system for the early care and education field which will have the capability and infrastructure to support training, coaching, mentoring, and networking statewide. Additional funding should be allocated so this system can be expanded to include the content, capacity, and expertise to support home visiting programs. This will facilitate resource sharing, communication, and local collaboration as well as the ability to most effectively and efficiently provide trainings to achieve core competencies. This quality improvement system should be available to all home visiting programs, including those of the Department of Children and Families.

[14] Could include demographics, educational backgrounds, types of occupations.

G) Report on Progress

There are many types of reporting already taking place: Programs already submit progress reports to funders (including MIECHV, OEC, and DCF), state agencies generate regular analyses of funded efforts and the Children's Report Card reports on population-level data.

The most valuable additional report would contain information on the home visiting field as a developing system and should be presented to legislators annually in a joint report in the Results Based Accountability (RBA) framework.

Report Audience	**Report**	**Population Level**	**Example Questions**
Legislature and Public	Children's Report Card on Outcomes	All families with young children	What are the rates of abuse and neglect? Are children arriving at school ready to learn?
Legislature	RBA	All *vulnerable* families with young children	How many families would benefit from home visiting services? Where are they? What percent of the targeted population is being served by home visiting programs or have access to a home visiting program appropriate for their needs?
State Agencies and Home Visiting Programs	Annual Reports	All families *actually served* by programs	How well are the programs serving the needs of families? Are families satisfied with the support provided?
Funders and Programs	Progress Reports	Families served by specific programs	What is the outcome of services provided by this program?

Recommendations:

16. **Establish annual RBA reporting on the home visiting system to the legislature from the OEC.**

The report should include the following components:

- *How much did we do?*
    - Describe the amount of home visiting services provided in the state including the current funding for home visiting and the utilization of services.
- *How well did we do it?*
    - Describe the success towards meeting the need that may include estimations based on risk factors, referrals, etc. as well as the additional funding required to meet the need for services and system development.
    - Describe the progress toward developing a home visiting system.
- *Is anyone better off?*
    - Describe family and child outcome measures, as available.

APPENDIX A: WORKGROUP PARTICIPATION

Home Visiting Systems Building Project
OFFICE OF EARLY CHILDHOOD

Guiding Document: Legistlation in Public Act 13-178 , Section 5 requires recommendations for implementing the coordination of home visiting programs within the early childhood system by Dec 1, 2014.

Work Team Members:

Name	Title
Adair, Maggie	Office of Early Childhood
Battista, Cathy	Family Resource Center Alliance
Cavacas, Marcie	Department of Public Health
DiMauro, Nancy	Department of Children and Families
Edwards, Doug	Real Dads Forever
Farnsworth, Mary	Office of Early Childhood
Foley-Schain, Karen	Office of Early Childhood
Goodman, Linda	Office of Early Childhood
Harris, Linda	Office of Early Childhood
Jensen, Monica	Nurse Consultant, Family Health Section, DPH
Johnson, Lynn	Birth to Three
Kramer, Mickey	Office of Child Advocate
Langer, Pam	Parents as Teachers
Lenihan, Catherine	Office of Early Childhood
Jones Taylor, Myra	Office of Early Childhood
Lowell, Darcy	Child First
Meyers, Judith	Children's Health and Development Institute
Peniston, Mary	Child FIRST
Storey, Janet	Department of Mental Health and Addiction Services
Whitney, Grace	Office of Early Childhood
Zimmerman, Elaine	Commission on Children

Workgroup Support provided by Connecticut Economic Resource Center: Bob Santy, Alissa Dejong, Carmel Ford, and Pat McLauglin.

APPENDIX B: NEEDS ASSESSMENT DATA REPORT

Connecticut Office of Early Childhood
home visiting Project
Identification of Population and Population with Risk Factors

Introduction

This section details general population and high risk population data for the purposes of identifying the need for home visiting services in Connecticut.

Data in this section provides an updated picture of the total population and populations at risk first presented in the Department of Public Health *Statewide Needs Assessment for Maternal, Infant, and Early Childhood home visiting programs* (2010). Select data points in this section were also included based on discussions during the home visiting meetings, which convened from July to November 2014. Data for this section was gathering on a statewide basis. Detailed breakdowns of the data available from the different sources listed.

Data for the section was gathered from several sources included, but not limited to, the Connecticut Department of Public Health, the Connecticut Department of Children and Families, the Department of Public Safety, and the US Census American Community Survey.

General Population Data

The home visiting system's high-level targeted population is families with young children (<eight years of age), and pregnant mothers. According to the 2013 US Census American Community Survey, 3,596,080 individuals were living in Connecticut comprising 1,339,860 households. Approximately 67 percent of Connecticut households consisted of family households with children. The number of children under the age of 6 in 2013 was 233,214 (about 29.8 percent of all Connecticut children).[15]

[15] A specific breakout of all children under the age of 8 is not available.

Table 1: Connecticut Population and Households, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent of households	Margin of Error
Total population	3,596,080	X	*****
Households	1,339,860	100%	7,005
Family households with children	890,293	66.5%	9,252

Table 2: Connecticut Total Population of Children and Children in Households, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent	Margin of error
Total children	785,342	100%	875
Children in households	783,006	99.7%	1,158
In households, under 3 years	109,301	13.9%	3,925
In households, 3 and 4 years	81,188	10.3%	3,708
In households, 5 years	42,800	5.4%	3,253
In households, 6 to 8 years	131,944	16.8%	5,181
In households, 9 to 11 years	136,696	17.4%	4,786
In households, 12 to 14 years	137,794	17.5%	5,154
In households, 15 to 17 years	143,283	18.2%	1,120
In group quarters	2,336	0.3%	664

Table 3: Connecticut Children Under 6 by Family Type, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent with children under 6	Margin of error
Children under 6 years in households	233,214	100.0%	3,130
Under 6 years in married-couple family household	160,623	68.9%	1,124
Under 6 years in household with male householder, no wife present	13,870	5.9%	1,840
Under 6 years in household with female householder, no husband present	57,512	24.7%	3,252

Table 4: Connecticut Women 15 to 50 who Gave Birth in the Last 12 Months, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent of Total	Margin of Error
Total births to Women 15 to 50	35,904	100%	3,443
Unmarried women who gave birth	11,504	32%	2,130
Married women who gave birth	24,400	68%	X

Table 5: Number of Children and Families in Connecticut Living in Homeless Shelters, 1st Quarter of 2013
Source: DSS Emergency Shelter Statewide Demographic Report, Connecticut Coalition to End Homelessness

	Data	Percent
Total persons	1,354	100.0%
0-2 years	261	19.3%
3-5 years	177	13.1%
6-13 years	316	23.3%

Table 6: Connecticut Children in Foster Care by Age Group, 2012
Source: National Data Archive on Child Abuse and Neglect

	Data	Percent
Less than 1 year	256	6%
1 to 5 years	1,159	26%
6 to 10 years	645	14%
11 to 15	1,020	23%
16 to 20	1,409	31%
Total	4,489	100%

Table 7: Connecticut Children in Foster Care Waiting for Adoption, 2012
Source: National Data Archive on Child Abuse and Neglect

	Data	Percent
Total number of children in Connecticut	785,342	100%
Children in foster care waiting for adoption	1,385	0.18%

Table 8: Children Ages 1 to 5 whose Family Members Read to Them Less than 3 Days per Week, Various Years
Source: Child Trends analysis of data from the U.S. Department of Health and Human Services

	Data	Percent
2003	27,000	12%
2007	20,000	10%
2011 - 2012	27,000	13%

Table 9: Number of Children under 3 whose Parents Did Not Receive a Home Visit, 2011-2012
Source: US Department of Health and Human Services

	Data	Percent
Children ages birth to 3 whose parent did not receive a new parent home visit	127,712	87%

Outcomes and Risk Factor Data

Home visiting outcomes in the DPH Needs Assessment are organized by two general outcome areas: Maternal, Birth, and Infant Outcomes, and Child Health and Development Outcomes. The following is a list of home visiting outcomes and risk factors that impact the outcomes:

Maternal, Birth, and Infant Outcomes

- Low Birth Weight and Preterm Birth
- Fetal and Infant Mortality
- Infant Deaths Due to Neglect or Abuse

Maternal, Birth, and Infant Risk Factors

- Infants Born into Poverty
- Late or No Prenatal Care
- Tobacco Use During Pregnancy
- Alcohol or Substance Use During Pregnancy
- Perinatal Depression (Data not available)[16]

Child Health and Development Outcomes

- Early Language Development (Data not available)[17]
- Early Scholastic Achievement (Connecticut Mastery Scores used as proxy)
- High School Dropout Rates
- Teen Parenthood and Low Educational Attainment

Child Health and Development Risk Factors

- Early Childhood Poverty
- Childhood Maltreatment (Data from the Department of Children and Families Allegations and Substantiation Report used as proxy)
- Intimate Partner Violence
- Parental Mental Health (especially depression)
- Parental Substance Abuse
- Homelessness
- Children Affected by Crime (Incarcerated parents data not available]

[16] No data on this risk factor was included in the DPH Needs Assessment.
[17] No data on this outcome was included in the DPH Needs Assessment. Households that do not speak English was used in replace of this outcome.

- Asthma and High Blood Lead Levels
- Children with Developmental Delays (Birth To Three screening and eligibility data used as proxy)

The following sections provide updated data for each outcome and risk factor listed above. Some data points originate from the same sources used in the DPH Needs Assessment; some originate from different sources.

Maternal, Birth, and Infant Outcomes

Table 10: Connecticut Low Birth Weights, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total births	37,277	100%
Low birth weight (<2500g)	2,885	8%
Very low birth weight (<1500g)	574	2%

Table 11: Connecticut Preterm Births, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total births	37,277	100%
After 37 weeks gestation	33,454	89.7%
Before 37 weeks gestation	3,794	10.1%
Unknown	29	0.1%

Table 12: Connecticut Fetal and Infant Mortality, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Rate
Fetal deaths	209	5.6 per 1000 births
Infant deaths	194	5.2 per 1000 births

Table 13: Connecticut Infant[18] Death Causes including Homicide and Accidents (proxy for Neglect and Abuse), 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total infant deaths	194	100%
Certain conditions originating in the perinatal period	111	57%
Congenital malformations	24	12%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	20	10%
Diseases of the circulatory system	8	4%
Diseases of the respiratory system	7	4%
Diseases of the nervous system	6	3%
Bacterial sepsis in newborn	6	3%
Certain infection and parasitic diseases	5	3%
Assault (homicide)	3	2%
Accidents (unintentional injuries)	2	1%
Unknown	2	1%

[18] Infant is defined as <365 days of life after birth

Maternal, Birth, and Infant Outcomes Risk Factors

Table 14: Connecticut Women, Ages 15 to 50, Who Gave Birth in the Last 12 Months by Poverty Level[19], 2013
Source: American Community Survey, US Census Bureau

	Data	Percent	Margin of Error
Women who had a birth in the past 12 months	35,889	100.0%	3,307
Women who gave birth, below the poverty level	7,796	22%	X
Women who gave birth, 100-199 percent of the poverty level	6,072	17%	X
Women who gave birth, 200 percent or more of the poverty level	22,021	61%	X

Table 15: Late or No Prenatal Care[20] in Connecticut, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total births	37,277	100.0%
Late or no prenatal care	4,800	12.9%

Table 16: Connecticut Births to Mothers Who Smoked During Pregnancy, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total births	37,227	100.0%
Smoked during pregnancy	1,729	4.6%

[19] Women 15 to 50 years for whom poverty status is determined (differs from 2013 total birth estimate).
[20] Late prenatal care is defined as prenatal care beginning in the second or third trimester of pregnancy.

Child Health and Development Outcomes

Table 17: Number of Connecticut Households that Consist of Persons Who Do Not Speak English "Very Well", 2013[21]
Source: American Community Survey, US Census Bureau

	Data	Percent speaking other language [not speaking English "very well"]
Total households	1,339,860	X
No one age 14 and over speaks English only or speaks English "very well"	73,692	100%
Spanish	19,455	26%
Other Indo-European Languages	13,854	19%
Asian and Pacific	18,939	26%
Other languages	9,727	13%

Table 18: Connecticut Mastery Test Results, 3rd Grade, 2013 (Proxy for Early Scholastic Achievement)
Source: Connecticut Mastery Test, 4th Generation

	Number of Students Tested	Average Scale Score (100-400)	Percent At/Above Goal Level	Percent At/Above Proficient Level
Mathematics	37,508	256	61.6	82.7
Reading	37,068	242.5	56.9	72.4
Writing	38,307	250.1	60	80.4

Table 19: Connecticut High School Drop Out Rate, School Year 2010-2011
Source: Information for Workforce Investment Planning, Connecticut Department of Labor

	Data	Percent
High school enrollment	170,255	100%
High school drop outs	4,377	2.6%

[21] A discussion was included in the DPH Needs Assessment on the importance of early child development, but data was not provided. In lieu, data on the number of households that have persons who do not speak English at all was used per discussion from the home visiting team meetings.

Table 20: Connecticut Births to Teenagers, 2011
Source: Vital Statistics, Connecticut Department of Public Health

	Data	Percent
Total births	37,277	100%
Births to mothers under 15	24	0.1%
Births to mothers under 18	560	2%
Births to mothers under 20	2,045	5%

Table 21: Connecticut Educational Attainment (for persons 25 years of age and older), 2013
Source: American Community Survey, US Census Bureau

	Data	Percent
Population 25 years and over	2,465,315	100%
Less than 9th grade	118,335	4.8%
9th to 12th grade, no diploma	150,384	6.1%
High school graduate (includes equivalency)	695,219	28.2%
Some college, no degree	424,034	17.2%
Associate's degree	160,245	6.5%
Bachelor's degree	507,855	20.6%
Graduate or professional degree	409,242	16.6%

Child Health and Development Outcomes Risk Factors

Table 22: Number of Connecticut Families with Incomes below Poverty Level, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent	Margin of Error
Total number of family households	890,293	100%	3,671
Families with incomes under the poverty line	110,426	12.40%	2,664

Table 23: Number of Connecticut Families with Incomes below Poverty Level, 2013
Source: American Community Survey, US Census Bureau

	Data	Percent of families with incomes under poverty line	Margin of Error
Families with incomes under the poverty line	110,426	100.0%	2,664
Married couple families, children under 5 years	6,621	3.5%	2,098
Male householder; no wife present, children under 5 years	2,980	2.0%	1,363
Female householder, no husband present, children under 5 years	22,631	11.4%	2,775

Table 24: Detailed Report on Total Abuse Allegations and Substantiations in Connecticut, FY 2014 (Proxy for Child Maltreatment)
Source: Connecticut Department of Children and Families

	Data	Percent of Accepted Reports
Total allegations	81,084	X
Accepted reports	30,577	100.0%
Substantiated reports	4,930	16.1%

Table 25: Detailed Report on Total Abuse Allegations and Substantiations in Connecticut, FY 2014 (Proxy for Child Maltreatment)
Source: Connecticut Department of Children and Families

	Allegations	Substantiated	Substantiation Rate
Physical abuse	8,175	494	6%
Educational neglect	2,448	551	23%
Emotional neglect	16,538	2,957	18%
High risk newborn	-	-	-
Medical neglect	1,771	355	20%
At risk	-	-	-
Physical neglect	47,317	9,048	19%
Sexual abuse	2,103	526	25%
Total allegations	81,084	14,251	18%

Table 26: Connecticut Family Domestic Violence Offenses and Victims, 2011 (Proxy for Child Maltreatment)
Crime Analysis Unit, Connecticut Department of Public Safety

	Offenses	Victims
Total	20,494	18,132
Homicide	18	18
Assault	6,618	5,693
Kidnapping	13	13
Sexual assault	107	108
Criminal mischief	131	131
Risk of injury	114	193
Breach of peace	4,214	3,578
Disorderly conduct	6,950	6,067
Other/ court order violation	2,329	2,331

Table 27: Number of Connecticut Children Involved or Present during Domestic Violence Incident, and Number of Child Victims, 2011
Crime Analysis Unit, Connecticut Department of Public Safety

	Data
Children involved	2,979
Children present	3,888
Children victims	-
0 -1 years	155
2 to 5 years	216
6 to 9 years	199

Table 28: Estimate of the Number of Children Who Have an Incarcerated Parent, 2007 (Proxy for the number of Connecticut children who have incarcerated parents/children affected by crime)
Source: Bureau of Justice Statistics, US Department of Justice

	Data	Percent
Incarcerated Parents	809,800	X
Number of children with parent in prison	1,706,600	2.30%

Table 29: Connecticut Children Screened for Lead Blood Levels, Prevalence and Incidence, 2012
Source: Annual Disease Surveillance Report on Childhood Lead Poisoning, Connecticut Department of Public Health

	Data	As a Percent of Screenings
Tests	82,536	X
Screenings of children under age 6	75,569	100%
Prevalence	-	-
greater or equal to 5 mg/dl	2,261	3.0%
greater or equal to 15 mg/dl	196	0.3%
greater or equal to 20 mg/dl	107	0.1%
Incidence	-	-
greater or equal to 5 mg/dl	1,647	2.2%
greater or equal to 15 mg/dl	152	0.2%
greater or equal to 20 mg/dl	191	0.3%

Table 30: Lifetime and Current Asthma Prevalence among Connecticut Children by Age, 2010
Source: The Burden of Asthma in Connecticut: 2012 Surveillance Report, Connecticut Department of Health

	Lifetime		Current	
	Percent	**95% CI**	**Percent**	**95% CI**
0 – 4 years	7.3	3.9-10.8	5.9	2.8-9.1
5 – 11 years	16.7	12.8-20.6	13.6	9.8-17.3
12 – 17 years	19.9	15.8-24	13	9.5-16.5

Table 31: Birth to Three data on Referrals and Program Eligibility [Proxy for Childhood Developmental Delays], FY 2013
Source: Connecticut Birth to Three System: 2013, Birth to Three

	Data	Percent
Children referred to birth to three	8,336	100%
Evaluations completed	7,780	93%
Children eligible	4,680	56%
Eligible due to developmental delays	4,160	50%
Eligible due to medical condition with high probability of later exhibiting developmental delays	521	6%

APPENDIX C: PROTECTIVE FACTORS FRAMEWORK

Protective Factor	Description
Parental Resilience	Resilience is the ability to manage and bounce back from all types of challenges that emerge in every family's life. It means finding ways to solve problems, building and sustaining trusting relationships including relationships with your own child, and knowing how to seek help when necessary.
Social Connections	Friends, family members, neighbors and community members provide emotional support, help solve problems, offer parenting advice and give concrete assistance to parents. Networks of support are essential to parents and also offer opportunities for people to "give back," an important part of self- esteem as well as a benefit for the community. Isolated families may need extra help in reaching out to build positive relationships.
Concrete Support in Times of Need	Meeting basic economic needs like food, shelter, clothing and health care is essential for families to thrive. Likewise, when families encounter a crisis such as domestic violence, mental illness or substance abuse, adequate services and supports need to be in place to provide stability, treatment and help for family members to get through the crisis.
Knowledge of Parenting and Child Development	Accurate information about child development and appropriate expectations for children's behavior at every age help parents see their children and youth in a positive light and promote their healthy development. Information can come from many sources, including family members as well as parent education classes and surfing the internet. Studies show information is most effective when it comes at the precise time parents need it to understand their own children. Parents who experienced harsh discipline or other negative childhood experiences may need extra help to change the parenting patterns they learned as children.
Social and Emotional Competence of Children	A child or youth's ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults, and peers. Challenging behaviors or delayed development creates extra stress for families, so early

	identification and assistance for both parents and children can head off negative results and keep development on track.

Appendix D: Nebraska's Universal Competencies

Nebraska's Universal Competencies

Universal Competency 1

Appreciates and recognizes the impact and role relationships play in the context of all learning, growth and change including, but not limited to, relationships between the child & other children, parent & child, parent & professional, professional & child, or professional & professional.

Universal Competency 2

Respects and accepts a family's expertise regarding their family system and children. Encourages family involvement and collaboration in all plan development and implementation from a strengths based approach.

Universal Competency 3

Recognizes the role culture plays in a family life and respects how it impacts their view of the world and choices in raising a family.

Universal Competency 4

Demonstrates core knowledge and the ability to infuse knowledge into practice in the areas of resiliency, child development, social-emotional development, attachment (healthy development of and impact of loss, stress or trauma), infant mental health principles, brain development, and the impact of risk factors on family and child development.

Universal Competency 5

Identifies the benefits of using a child and family's natural environments and routines for learning and demonstrates the ability to increase the consistency, predictability, and engagement qualities of these areas.

Universal Competency 6

Recognizes the value of play, language and literacy in learning and the development and nurturing of relationships.

Universal Competency 7

Demonstrates empathy for all individuals and the ability to see from the child's perspective (thinking about how the adult's actions are interpreted through the eyes of the child).

Universal Competency 8

Demonstrates awareness of the developmental phases and behaviors of a family and the ability to support the family to navigate effectively through transitions.

Universal Competency 9

Recognizes the components of quality observation and assessment and uses the information to inform practice.

Universal Competency 10

Is active in one's own professional development plan – seeking advancement of knowledge for application to service provision.

Universal Competency 11

Identifies the benefits of quality reflective supervision, demonstrating the ability to reflect on one's own bias, and personal reactions to working with children and families.

Home Visiting	**Parents as Teachers/MIECHV**	**Nurturing Families Network**	**CT AIMH**	**Child First**	**Early Head Start**	**Certificate in Infant Toddler Care**
Home visitors receive intensive training specific to their role to understand the essential components of family assessment and home visiting. The home visitor develops knowledge and awareness of the signs of depression, trauma, homelessness, domestic violence, and/or mental illness. The home visitor develops a basic knowledge of health, mental health, child development, and disabilities to ensure service coordination.	Life Skills Progression Training **Core Competency Child and Family Development** Parent Educators are knowledgeable about child and parent development and are skilled in fostering positive parent-child interactions.	**Home Visitor Credential** KEMPE Training Life Skills Progression Training Nurturing Families In Action Training Touchpoints Training **PAT Core Competency Child and Family Development** Parent Educators are knowledgeable about child and parent development and are skilled in fostering positive parent-child interactions.	**Competency: Thinking** Skill area; Analyzing information, solving problems, exercising sound judgement, maintaining perspective, planning and organizing **Competency: Theoretical Foundations** Knowledge Areas: pregnancy & early parenthood, infant & young child development and behavior, infant/young child and family-centered practice, relationship-based practice, family relationships and dynamics, attachment, separation and loss, cultural competence.	**Child First Learning Collaborative Curriculum** Learning Session 1 Online Learning 1 Module II: Infant and Child Development Module III: Caregiver Development Module IV: Attachment and Relationships Module V: Assessment	**Relation Based Competencies** **Family Well-Being and Families as Learners,** Enhances the parent-child relationship, and supports parents' role as the first and lifelong educators of their children. **Coordinated, Integrated and Comprehensive Services** Acts as a member of a comprehensive services team so that family service activities are coordinated and integrated throughout the program.	**Core Competencies** Identify the developmental domains and explain their interrelation with early learning and development. Know how to form strong attachments with a baby and why a strong attachment is important. Demonstrates an understanding of how infants and toddlers grow and develop socially, emotionally, physically, and cognitively in order to create realistic expectations and provide quality early learning experiences for infants and toddlers.

Appendix E: Model Descriptions

Not yet included.